

10666

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN TB <b>77 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 CRISFIELD</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREARY MEMO. HOSP.</b>				d. STREET ADDRESS <b>1 MAIN STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>C CHARLES</b>		First Middle Last <b>HUBBARD DAUGHERTY</b>		4. DATE OF DEATH Month Day Year <b>SEPTEMBER 19 1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-3-1882</b>	
				9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Investments</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles O. Daugherty</b>				14. MOTHER'S MAIDEN NAME <b>Maggie Dize</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>MARY M. DAUGHERTY, CRISFIELD, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Angina pectoris</b> DUE TO <b>Coronary arterio sclerosis</b> (c) <b>Coronary arterio sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 years</b> <b>yes</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1948</b> to <b>SEPT. 19 1959</b> , that I last saw the deceased alive on <b>SEPT. 19 1959</b> , and that death occurred at <b>10:35 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CRISFIELD, MARYLAND</b> DATE SIGNED <b>9/20/59</b> ACTUAL SIGNATURE <b>C. G. RAWLEY</b> M.D. <b>CRISFIELD, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>C. G. RAWLEY, M.D.,</b> <b>CRISFIELD, MARYLAND</b>							
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 22, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hume</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 3.7 FilmG249 10-6-59 et  
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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution? Residence before admission?) b. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Fairmount</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>✓</u>	
3. NAME OF DECEASED (Type or print) <u>Algia (Algie) (Buoy) Middle Last</u>		4. DATE OF DEATH <u>Sept 26 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 8, 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm A. Ford</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Munnings Ford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>in</u>	
17. INFORMANT <u>Elveth Ford</u>		Address <u>Balto</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-Vascular</u> DUE TO (c) <u>Renal Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 55</u> to <u>Sept 26 1959</u> , that I last saw the deceased alive on <u>Sept 25</u> , 19 <u>59</u> , and that death occurred at <u>5:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Frank Giganti</u> M.D.		ADDRESS (Street, city or town, state) <u>Princeton Anne Md</u>	
PHYSICIAN'S NAME (Type) <u>B. FRANK GIGANTI</u>		DATE SIGNED <u>9/26/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 27, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Kelley Upper Fairmount Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry B. Miles</u> ADDRESS <u>Upper Fairmount Md</u>		24a. RECEIVED BY REGISTRAR <u>SEP 29 59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Cuthbert &amp; Thoms</u>	



10668

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>				c. LENGTH OF STAY IN 1b <b>6 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>E.W. MCCREARY MEMO. HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>DEBORAH ANNE HOLDEN</b>				4. DATE OF DEATH Month Day Year <b>SEPT 7TH 1959</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 7, 1959</b>	
9. AGE (In years lost birthday) yrs. <b>1</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>1</b>		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>CRISFIELD, Md.</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>ISAAC HOLDEN</b>				14. MOTHER'S MAIDEN NAME <b>ROSALEE WILLIAMS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>ISAAC HOLDEN</b>				Address <b>MARION STATION, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>756.0</b> DUE TO <b>Reliability Acute of Heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Pyloric Spasm</b> (c) <b>malnutrition</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9-1-59</b> to <b>SEPT 7TH 1959</b> that I last saw the deceased alive on <b>SEPT 7TH 1959</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>9/8/59</b>			
PHYSICIAN'S NAME (Type) <b>GEORGE C. COULBOURN, M.D., MARION STATION, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>SEPT 10-59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>FAMILY</b>				22d. LOCATION (City, town, or county) (State) <b>MARION STATION, MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Howard Marion Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 17 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>							

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CONFIDENTIAL

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STATEMENT OF WORK

10001

1. The purpose of this statement is to define the scope of work for the project.

2. The project is to develop a new software application for the company.

3. The project will be completed by the end of the year.

4. The project will be managed by the project manager.

5. The project will be funded by the company.

6. The project will be subject to the company's policies and procedures.

7. The project will be subject to the company's risk management process.

8. The project will be subject to the company's quality management process.

9. The project will be subject to the company's change management process.

10. The project will be subject to the company's communication management process.

11. The project will be subject to the company's stakeholder management process.

12. The project will be subject to the company's resource management process.

13. The project will be subject to the company's procurement management process.

14. The project will be subject to the company's contract management process.

15. The project will be subject to the company's legal management process.

16. The project will be subject to the company's financial management process.

17. The project will be subject to the company's human resources management process.

18. The project will be subject to the company's information management process.

19. The project will be subject to the company's security management process.

20. The project will be subject to the company's compliance management process.

AVAIL



10669

## CERTIFICATE OF DEATH

10652

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAMES QUARTER</u>		c. LENGTH OF STAY IN 1b <u>LIFETIME</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u>		d. STREET ADDRESS <u>MAIN ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>RUTH E. JONES</u>		4. DATE OF DEATH <u>Sept. 24 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 4-1894</u>
9. AGE (In years lost birth day) <u>64 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEHOLD DUTIES</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MATTHEW ROXBURY</u>		14. MOTHER'S MAIDEN NAME <u>CHARLOTTE ROBERTS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-K-7787</u>	
17. INFORMANT <u>LUTHER JONES</u>		Address <u>DAMES QUARTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 443X DUE TO Congestive failure (b) <u>Hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Hypertensive cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>3 wks</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 2</u> , 19 <u>59</u> , to <u>Sept 24</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Sept 24</u> , 19 <u>59</u> , and that death occurred at <u>2a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Everett C. Sutter</u>		ADDRESS (Street, city or town, state) <u>Dames Quarter, Maryland</u> DATE SIGNED <u>9-25-59</u>	
PHYSICIAN'S NAME (Type) <u>Everett C. Sutter MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Macdonia Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Dames Quarter Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Webster</u>		ADDRESS <u>Deal Island Md.</u>	
24a. REC'D BY REGISTRAR <u>1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Thoma</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEED

Blank form with horizontal lines for text entry.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10670

## CERTIFICATE OF DEATH

Reg. Dist. No.

10653

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pocomoke City</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. 1</b>		e. STREET ADDRESS <b>R.F.D. 1</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>L.</b> Last <b>LONG</b>		4. DATE OF DEATH Month <b>September</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Powell</b>		14. MOTHER'S MAIDEN NAME <b>Harriett W. Dryden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Maurice S. Long, RFD 1, Pocomoke City, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Oedema</b> DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Degenerative Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Nephritis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  <b>years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 8, 1950</b> to <b>Sept. 24, 1959</b> , that I last saw the deceased alive on <b>Sept. 24, 1959</b> , and that death occurred at <b>130P M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles W. Trader, M.D. 302 Market St., Pocomoke City, Md. 9/26/59</b>			
ACTUAL SIGNATURE <b>Charles W. Trader</b>		PHYSICIAN'S NAME (Type) <b>Charles W. Trader, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-27-59</b>	
22c. NAME OF CEMETERY <b>Rehobeth Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Rehobeth, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>		24a. REC'D BY REGISTRAR <b>SEP 29 '59</b>	
ADDRESS <b>Pocomoke City, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1893

Name of Deceased		Age		Sex		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Registrar		Signature of Medical Officer	
John Smith		45		Male		Married		Labourer		Heart Disease		15th Dec 1893		15th Dec 1893		J. Smith		Dr. Jones	
Place of Birth		Date of Birth		Date of Marriage		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Exhumation		Date of Re-interment		Date of Re-cremation	
London		1st Jan 1848		1st Jan 1878		15th Dec 1893		16th Dec 1893		16th Dec 1893									
Place of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Exhumation		Date of Re-interment		Date of Re-cremation		Date of Re-interment		Date of Re-cremation	
15th Dec 1893		15th Dec 1893		16th Dec 1893		16th Dec 1893													
Signature of Registrar		Signature of Medical Officer		Signature of Coroner		Signature of Police Officer		Signature of Health Officer		Signature of Sanitary Officer		Signature of Water Officer		Signature of Gas Officer		Signature of Sewerage Officer		Signature of Fire Officer	
J. Smith		Dr. Jones		Mr. Brown		Mr. Green		Mr. White		Mr. Black		Mr. Grey		Mr. Blue		Mr. Yellow		Mr. Purple	

This certificate is to be filled up by the Registrar of Births and Deaths, and is to be signed by the Registrar, the Medical Officer, the Coroner, the Police Officer, the Health Officer, the Sanitary Officer, the Water Officer, the Gas Officer, the Sewerage Officer, and the Fire Officer.

10671

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke Life Line</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		4. STREET ADDRESS <u>R 20 #1</u>	
e. US RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wells</u> Last <u>Gong</u>		4. DATE OF DEATH Month <u>9</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15 1894</u>
9. AGE (In years last birthday) <u>64</u>		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>14</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Packing</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Handy</u>		14. MOTHER'S MAIDEN NAME <u>Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-42</u>	
17. INFORMANT <u>Mrs Wells Long Pocomoke Md</u>		Address <u>RA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of Lung</u> 167X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Probably Cigarette Smoking - Heavy</u> (c) <u>Ex. Ino. - Cancers</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 9th</u> , 19 <u>59</u> , to <u>Sept 29th</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 26th</u> , 19 <u>59</u> , and that death occurred at <u>11</u> M, from the cause and on the date stated above.			
ACTUAL SIGNATURE <u>M.E. Santorius</u> M.D.		ADDRESS (Street, city or town, state) <u>Pocomoke City, Md</u>	
PHYSICIAN'S NAME (Type) <u>N. E. Santorius</u>		DATE SIGNED <u>9/30/59</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-4-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Whitten - New Church, G.</u>		24a. REC'D BY REGISTRAR <u>Oct 8 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10672

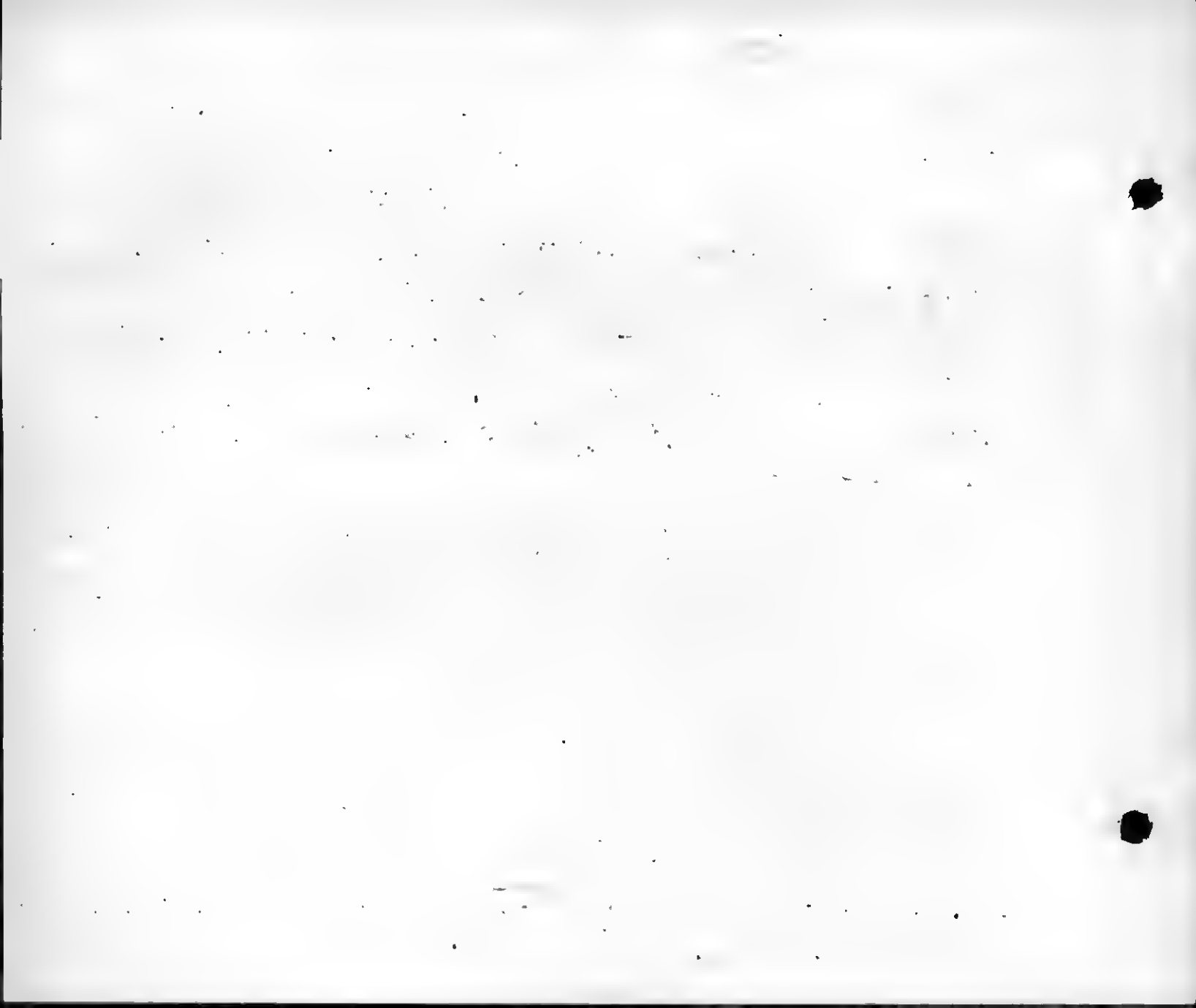
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>		c. LENGTH OF STAY IN 1b <u>Princess Anne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1253 Church Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Catherine</u> Last <u>Maddox</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24 - 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u>17</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>work for C&amp;P Tele</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Rockawaylin Wicomico Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>IVRING PARSONS</u>		14. MOTHER'S MAIDEN NAME <u>SARAH THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>215-20-428</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>Cardiac Decompensation</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <u>Renal Disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 yr.</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar</u> , 19 <u>58</u> , to <u>Sept 9</u> , 19 <u>59</u> , that I lost saw the deceased alive on <u>Sept 9</u> , 19 <u>59</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Frank Giganti</u>		DATE SIGNED <u>Princess Anne 9/11/59</u>	
PHYSICIAN'S NAME (Type) <u>B. FRANK GIGANTI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Sept. 13, 1959</u>	<u>Metropolitan</u>	<u>Princess Anne, Som. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Ward - Marion Sta., Md #235</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 17 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





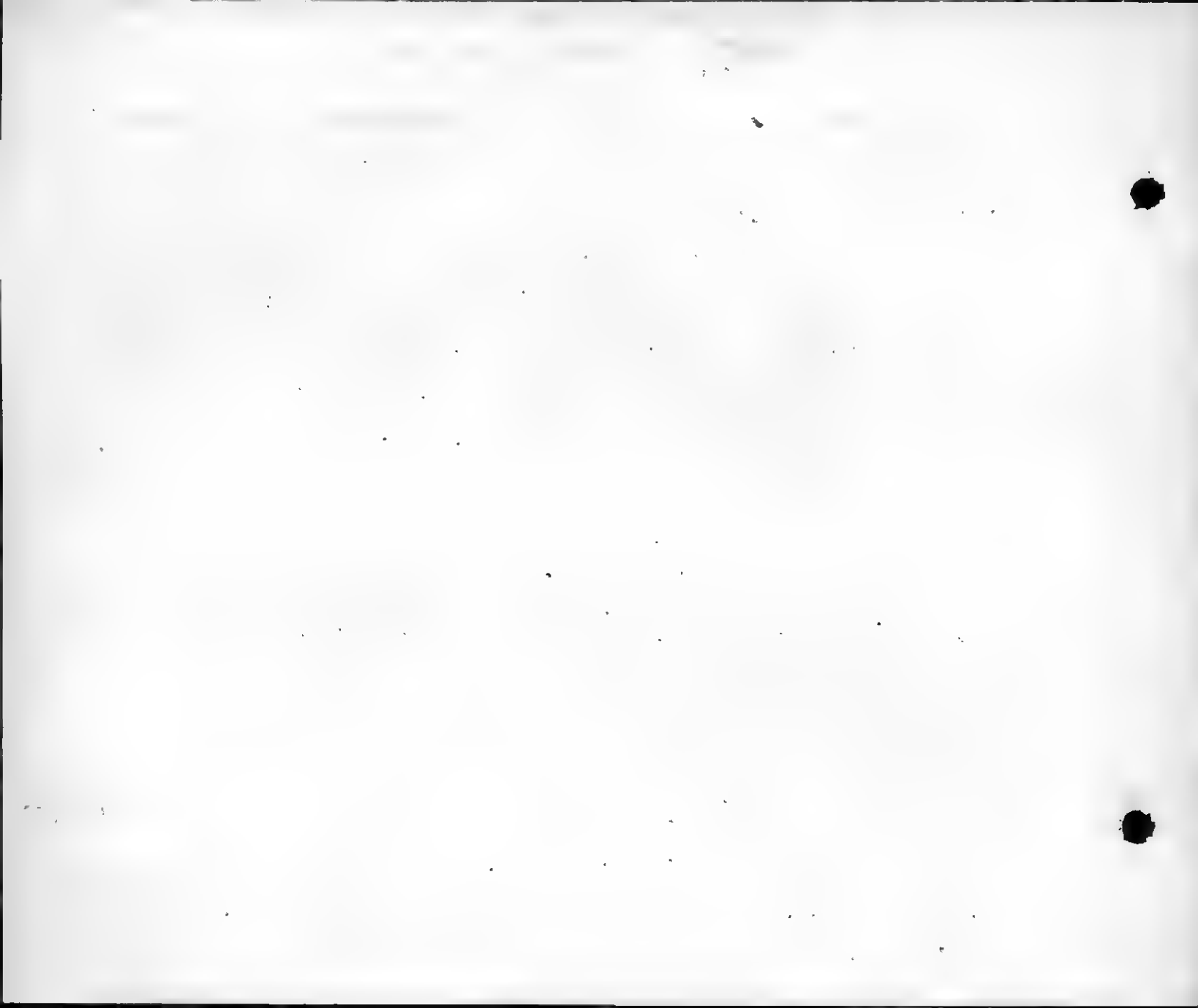
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b> c. LENGTH OF STAY IN 1b <b>5 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>E.W. MCCREADY MEMO. HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RUMBLEY</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Middle <b>M.</b> Last <b>MEREDITH</b>		4. DATE OF DEATH Month <b>SEPT</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 18, 1895</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min. <b>64</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN FRENCH</b>		14. MOTHER'S MAIDEN NAME <b>ESTHER BLAKE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>DULANEY MEREDITH RUMBLEY, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Scl of Heart</b> <b>260X</b> DUE TO <b>Triable Malnutrition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Myocardial infarction</b> DUE TO <b>Myocardial infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General Arteriosclerosis Cerebral Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 59</b> to <b>SEPT 7, 1959</b> , that I last saw the deceased alive on <b>SEPT 7TH, 1959</b> , and that death occurred at <b>5:55 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Marion Station, Maryland</b> DATE SIGNED <b>9/8/59</b> ACTUAL SIGNATURE <b>George C Coulbourn, M.D.</b> PHYSICIAN'S NAME (Type) <b>GEORGE C COULBOURN, M.D.</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>Sept. 10, 1959</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Mechanics Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Fairmount, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 14 '59</b> DATE <b>SEP 14 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
1SM 9/58



## CERTIFICATE OF DEATH

Reg. Dist. No.

10656

10674

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN TB <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X KINGSTON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMORIAL HOSP.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>WHITTINGTON</b> Last <b>WHITTINGTON</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18-1879</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>L</b>		10c. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JEFF WHITTINGTON</b>				14. MOTHER'S MAIDEN NAME <b>LOUISE Fields</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>216-12-1818</b>		INFORMANT Address <b>BERNICE WHITTINGTON, KINGSTON, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Inf of Heart</b> DUE TO <b>Chronic myocardial disease and myopathies</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>General Arterio Sclerosis</b> DUE TO (b) <b>General Arterio Sclerosis</b> DUE TO (c) <b>General Arterio Sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4-5 hrs</b> <b>yes</b> <b>yes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1</b> , 19 <b>59</b> , to <b>Sept 15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 14</b> , 19 <b>59</b> , and that death occurred at <b>6:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MARION, MARYLAND</b> DATE SIGNED <b>9/15/59</b>							
ACTUAL SIGNATURE <b>George C. Coulbourn</b>		M.D. <b>GEORGE C. COULBOURN, M.D.</b>		MARION, MARYLAND			
PHYSICIAN'S NAME (Type)		<b>GEORGE C. COULBOURN, M.D.</b>		<b>MARION, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Sept 17-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WATERS CHAPEL</b>		22d. LOCATION (City, town, or county) (State) <b>MARION SOM, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Ward</b>				ADDRESS <b>marion md</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Coulbourn &amp; Kneiss</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8/2/2019

100.0

## 10675 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10657

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u> c. LENGTH OF STAY IN 1b <u>Marion Station</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u> d. STREET ADDRESS <u>Marion Station Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Broudas</u> First <u>Williams</u> Middle <u>Williams</u> Last		4. DATE OF DEATH Month <u>Sept.</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1941</u>
9. AGE (In years last birthday) <u>17</u> yrs.		10. IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Marion Station</u>	
13. FATHER'S NAME <u>Thomas Wittiams</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Beauchamp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>216-38-233</u>	
17. INFORMANT <u>Thomas Williams</u>		Address <u>Marion Sta., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto Mobile Accident</u> 823X DUE TO <u>Fractured Skull - Lacerated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Left Forehead -</u> DUE TO <u>Shock</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART I. (a) <u>Shock</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9.45</u> a. m. <u>1959</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Marion Station</u>		20f. (City or town) <u>Marion Station</u> (County) <u>Somerset</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Wm. H. Coulbourn</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Wm. H. Coulbourn MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 29 '59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Branch</u>		22d. LOCATION (City, town, or county) (State) <u>Marion Sta., Som. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Ward</u>		24a. REC'D BY REGISTRAR <u>Oct 6 '59</u>	
ADDRESS <u>Marion Sta., Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Colburn &amp; Thrane</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

10658

10665

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12 Main St.</b>		d. STREET ADDRESS <b>12 Main St.</b>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>CULLEN</b> Last <b>WYATT</b>		4. DATE OF DEATH Month <b>September</b> Day <b>21</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7, 1866</b>
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Cullen</b>		14. MOTHER'S MAIDEN NAME <b>Melissa Ward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs. Pearl Muir, 12 Main St., Crisfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
21. I certify that I attended the deceased from <b>Sept 21, 1959</b> to <b>Sept 21, 1959</b> that I last saw the deceased alive on <b>Sept 21, 1959</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D. <b>33 W. Main St.</b> DATE SIGNED <b>9/24/59</b>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M. D.</b>		<b>Crisfield, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept 23, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b> ADDRESS		24a. REC'D BY REGISTRAR DATE <b>SEP 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Catharine L. Kline</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

